Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS PAIN SOLUTIONS
REZIK A SAQER
PO BOX 19370
HOUSTON TX 77224-9370

Respondent Name
American Zurich Insurance Company

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2548-01

MFDR Date Received
March 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…This is not how the State of Texas Workers Compensation Guidelines are to be followed.""

Amount in Dispute: $587.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill for additional review and it remains in process at this time."

Response Submitted by: Gallagher Bassett, 6504 Intl Pkwy, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 210 and August 13, 2010	CPT Codes 64483, 64484 and 99214	$587.40	$575.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 24, 2010

- BL – SECTION 413.042 OF THE TEXAS LABOR CODE PROHIBITS A PROVIDER FROM BALANCE BILLING AN INJURED WORKER FOR WORKERS COMPENSATION COMP
- BL – TO AVOID DUPLICATE BILL DENIAL. FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT
- 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 12 – (125) PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CO
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Did the requestor include a bill and EOB for all codes submitted on DWC-60?
2. Did the requestor obtain prior authorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted a dispute for procedure code 99214. 28 Texas Administrative Code §133.307 details requirements for submitting a medical fee dispute and states in pertinent part, " a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance, and a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of submitted documentation finds no copy of bill or carrier's explanation of benefits for procedure code 99214 on date of service August 13, 2010. Therefore requirements of 133.307 are not met, no additional payment can be recommended.

2. The insurance carrier denied disputed services billed under procedure code 64483 with reason code 19 – (197) "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT". Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." Documentation was found to support that this service had been preauthorized. The insurance carrier's denial reason is not supported. Reimbursement for procedure code 64483 is recommended.

   Services billed under procedure code 64484 were denied with reason code 12 – (125) "PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODE". Review of the submitted documentation finds the charges were prior authorized and authorization number was indicated on the claim. The carrier's denial reason is not supported. Reimbursement for procedure code 64484 is recommended.

3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2010, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or:

Code	MAR Calculation	Units	Allowable
64483	(54.32 / 36.8729) x 258.19	1	$380.36
64484	(54.32 / 36.8729) x 132.23	1	$194.80
		Total	$575.16

The total allowable for the disputed services is $575.16. The carrier paid $0.00. An additional payment of $575.16 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $575.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $575.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.